Council of Governors Meeting
9.15am to 12.00pm on Tuesday 14 April 2015

Mickerson Hall, Chichester Medical Education Centre, St Richard’s Hospital,
Spitalfield Lane, Chichester, PO19 6SE

AGENDA

1 9.15 Welcome and Apologies for Absence  Mike Viggers

2 9.15 Declarations of Interests  Verbal  Mike Viggers

3 9.15 Minutes of Meeting of the Council of Governors held on 22 January 2015 To approve  Enclosure  Mike Viggers

4 9.20 Matters Arising from the Minutes  To note  Enclosure  Mike Viggers

ASSURANCE

5 9.25 Chief Executive’s Update  To receive and agree any necessary action  Enclosure  Marianne Griffiths

6 9.45 Lead Governor’s Report  To receive and agree any necessary action  Enclosure  Margaret Bamford

7 9.55 CCG Strategic Commissioning Intentions  Introduction by Marianne Griffiths
Marie Dodd, Chief Operating Officer
NHS Coastal West Sussex Clinical Commissioning Group

8 10.35 Membership Committee Update  To receive and agree any actions  Enclosure  Vicki King

9 10.40 Holding Non-Executive Directors to Account  To receive and agree any actions  Enclosure  Richard Farmer

10 10.45 Staff Engagement  To note  Presentation  Denise Farmer

11.00 BREAK

GOVERNANCE

11 11.10 PEFC / SIRI Feedback  To note  Presentation  Bill Brown

12 11.35 Deputy Lead Governor Proposal  For decision  Enclosure  Abigail Rowe
Jane Ramage

OTHER ITEMS

13 11.45 Other Business  Chair
Questions from the Members of the Public

14  11.55  **Resolution into Board Committee**
To pass the following resolution:

“That the Council now meets in private due to the confidential nature of the business to be transacted.”

15  11.55  **Date of Next Meeting**

The next meeting of the Council of Governors is scheduled to take place on 16 July 2015 at 9.30am in the Doric Room, Charmandean Centre, Forest Road, Worthing, West Sussex, BN14 9HS

**Andy Gray**
**Company Secretary**
Tel: 01903 285288
Minutes of the Council of Governors Meeting held in Public from 09.30 am on Thursday 22 January 2015 at the Charmedean Centre, Forest Road, Worthing, West Sussex, BN14 9HS

Present:
- Mike Viggers, Chairman
- Margaret Bamford, Public Governor – Arun
- Margaret Boulton, Public Governor – Arun
- Barbara Porter, Public Governor – Adur
- John Todd, Public Governor – Adur
- Vicki King, Public Governor – Chichester
- Stuart Fleming, Public Governor – Chichester
- Shirley Hawkridge, Public Governor – Worthing
- David Langley, Public Governor – Worthing
- Beda Oliver, Public Governor – Worthing
- Paul Benson, Patient Governor
- Jennifer Edgell, Patient Governor
- Richard Farmer, Patient Governor
- Greg Daliling, Staff Governor
- Jenny Garvey, Staff Governor
- David Walsh, Staff Governor
- Shirley Bach, Appointed Governor, Head of School of Health Sciences, University of Sussex
- Robert Hayes, Appointed Governor, Chichester District Council
- Jane Ramage, Appointed Governor, Friends of WSHFT Hospital and WRVS
- Val Tuner, Appointed Governor, Worthing Borough Council

In Attendance:
- Joanna Crane, Non-Executive Director
- Jon Furmston, Non-Executive Director
- Lizzie Peers, Non-Executive Director
- Martin Phillips, Non-Executive Director
- Marianne Griffiths, Chief Executive
- Dr George Findlay, Medical Director
- Karen Geoghegan, Director of Finance
- Jane Farrell, Chief Operating Officer
- Denise Farmer, Director of Organisational Development and Leadership
- Vivienne Colleran, Director of Clinical Effectiveness, Research and Innovation
- Maggie Davies, Deputy Director of Nursing
- Andy Gray, Company Secretary
- Mike Jennings, Commercial Director
- Barbara Mathieson, Assistant to Company Secretary

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<tr>
<th>Item No</th>
<th>Item Title</th>
<th>Action</th>
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<tr>
<td>COG/1/15/1</td>
<td>Welcome and Apologies for Absence</td>
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<tr>
<td>1.1</td>
<td>The Chair welcomed everyone to the meeting of the Council of Governors. Mike Viggers also thanked the following for their contribution whilst Governors, Mike Rymer, John Gooderham and Martin Harbour.</td>
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1.2 Apologies for Absence were noted from:

Non-Executive Director – Bill Brown
Governors – Helen Dobbin, Brian Hughes, Alison Langley, Abigail Rowe

COG/15/2 Declarations of Interest

2.1 There were no declarations of interest.

COG/15/3 Minutes of the Council of Governors Meeting held in Public on 14 October 2014

3.1 The Council of Governors received the minutes of the meeting held on 14 October 2014.

3.2 COG/10/14/6.1 Change word updated to update.

3.3 COG/10/14/7.7 Change word affect to effect.

3.4 The minutes of the meeting of the Council of Governors held on the 14 October 2014 were approved, subject to the amendments above, and it was agreed that they could be signed by the Chairman.

COG/15/4 Matters Arising from the Minutes

4.1 The Matters Arising from the meeting held on the 14 October 2014 were noted by the Council of Governors.

4.2 COG/10/14/7.16 Update on Private Patients

It was confirmed that this would take place at a future Council of Governors Seminar/Briefing.

4.3 COG/10/14/8.3 Invite to CCG to attend Council of Governors Meeting.

It was confirmed that Marie Dobbs, Chief Operating Officer for Coastal West Sussex Clinical Commissioning Group had accepted the invitation to attend the meeting on 14 April 2015.

COG/15/5 Chief Executive’s Performance Report

5.1 Marianne Griffiths, Chief Executive Officer presented the Performance Report and spoke about the recent high levels of activity across the Trust.

5.2 Marianne commended the Trust’s two Accident and Emergency Departments and noted that they had excellent staff and that normally their performance was between 2 and 3% better than the national average. It was however noted that for Quarter 3 (Oct to Dec) 2014/2015 the A&E Performance for Western Sussex Hospitals NHS Foundation Trust (WSHFT) was 91.93% against a target of 95%. National performance for the same period was 88.9% and for other providers in Surrey and Sussex (excluding WSHFT) it was 89.9%. For December 2014 it was noted that the Trust’s A&E performance was 85.99% compared to 84.2% nationally and 85.9% for Surrey and Sussex providers (excluding WSHFT).
5.3 Over for the period attendances were high and with this was associated with an increase in the number of patients needing admission. It was particularly noted that there was a 15% increase in admissions in patients aged over 85.

During the period of November, December 2014 and also into January 2015 the capacity of the hospital was further constrained by a lack of available social care packages, community beds, and access to rehabilitation. At one point it was noted that the Trust had 111 patients available for discharge at Worthing and 76 at St Richards who were medically fit for discharge but the right package of care was not in place, therefore preventing discharge. It was also noted that during the peak periods there had been workforce constraints.

Marianne outlined the potential financial consequences of the increased activity which included potential fines for not achieving the 95% A&E four hour waiting target and for not meeting the 18 week referral to treatment time requirements. It was also noted that the extra cost of escalation beds and staffing to cover the increase demand was expected to be in the region of £1.5m. Marianne also described the range of measures that were undertaken throughout the Trust to mitigate demand to expedite discharge to maintain patient flow. These actions were coordinated with Local Health Economy partners.

Marianne complimented and thanked the staff of the Trust who had, and were continuing to, work very hard to deal with the unprecedented activity and to deliver an appropriate standard of care. She also thanked the Governors and other volunteers who had recently come into the Trust to help provide additional support.

5.7 Marianne then took the opportunity to update the Council of Governors on the plans for Southlands Hospital and reminded them of the background which had led to the plans to develop the hospital as a Centre for Amublatory Care and Ophthalmology. She explained that in 2010 the Hospital was mainly undertaking major orthopaedic inpatient cases and that a group of Consultants had presented the case to the Medical Director that the service was unsafe, partly due to lack of direct access to critical and cardiac care.

A full review was undertaken which supported the concerns and highlighted that the mortality rate was significantly higher than for the rest of the Trust. This was not acceptable and the services were centralised back to Worthing and a service redesign programme was undertaken. It was agreed with Local Health Economy Partners that the best use of the facilities at Southlands was as Community Beds and over a nearly three year period over twenty organisations were approached with this opportunity but no organisation was willing to undertake the opportunity. Therefore in October 2013 the Harness Block at Southlands was declared surplus to requirements and that the land would be sold with the proceeds being reinvested to develop a state of the art Ophthalmology Centre for the local residents. It was also noted that additional funding would be required from the Trust to complete the plans.

To conclude her item Marianne confirmed that Planning Permission for the excess land at Southlands Hospital had been granted by Adur District Council earlier in the week.

Margaret Bamford asked what the expected timescales would be for the
opening of the new Ophthalmology Centre at Southlands and Marianne confirmed it was hoped that the sale of the land would be completed by the end of March 2015 and it was expected that the new centre would be open by June 2016. Vicki King asked for confirmation that the sale of the land at Southlands would not cover all of the costs of the new Ophthalmology Centre and Marianne confirmed that was the case. Further capital investment would be required by the Trust. Vicki King also asked for a comparison of capital investment in the three hospital sites since the formation of the Trust at the next meeting in April and this was agreed.

5.11 Jane Ramage asked for further information regarding the treatment of Macular Degeneration cases at Goring Hall. Marianne confirmed that there had been 23% increase in referrals of these cases and that the local Clinical Commissioning Group had commissioned Goring Hall as an interim provider to manage the current unacceptable delays in the service. It was confirmed that it was expected that the service would return to the Trust in due course.

5.12 Stuart Flemming asked about the provision of appropriate care packages for patients being discharged and asked if there were concerns around the West Sussex Assessment Team. Jane Farrell confirmed that the Trust and the Assessment Team were working collaboratively but that there had been no uplift in Social Workers to support the Assessment Team to deal with the increased capacity demands and acuity of patients. However, Jane confirmed that six new Social Workers would be in place from the 1st February 2015, and that the Trust applauded the work of the community and social work teams over the recent period of unprecedented activity.

5.13 David Walsh asked if a complete review of the recent period of escalation and business continuity would be undertaken. Jane Farrell confirmed that Jane McGoven would be leading on this review and plans were in place to meet with individual operational teams in order to get feedback. It was agreed that feedback from this review would be brought to the Council of Governors meeting in April 2015.

5.15 Richard Farmer congratulated the Trust on once again achieving the four hour A&E target across the Trust during week ending 19 January 2015 when the rate was noted to be 98.19%. He asked however, what were the main lessons given that traditionally both January and February were months when attendance was higher. Marianne Griffiths confirmed the major need for the Trust was a more robust work force strategy as there was currently no flexibility within the system.

Paul Benson reminded the Council of Governors that the situation with Accident and Emergency Departments had been a national issue and that the Trust had coped better than many others including those most local. As such the Trust should be commended.

COG/1/15/6 Lead Governor’s Report

6.1 Margaret Bamford presented the Lead Governors Report and particularly commended how the involvement of Governors had become integral in a range of areas of work within the Trust over the last year.

6.2 She noted the changes in Governors from the last meeting and welcomed
Brian Hughes who had been elected as a Public Governor for Arun.

Margaret highlighted several points from her report including:

- That the Governors would be provided with redacted minutes from the Trust Board held in private for a trial period.
- The Nomination and Remuneration Committee had successfully appointed a new Non-Executive Director - (Clinical)
- Work had begun on a process of dealing with non-compliance with the Governors Code of Conduct
- The Membership Committee in particular had been active in seeking people to become members of the Trust.

6.3 The Council of Governors APPROVED the Terms of Reference for the Patient Engagement and Experience Committee.

6.4 It was noted that a Governor Strategy Group had been formed to secure active governor engagement in the development of the ongoing Strategy of the Trust.

6.5 Joanna Crane confirmed that at the Patient Experience and Feedback Committee the Non-Executive Directors randomly selected three closed complaints for review and scrutiny.

**Membership Committee Update**

7.1 Vicki King, Chair of the Council of Governors Membership Committee, gave an update on their current focus of activity which had included the aim of making contact with all GP surgeries within the Western Sussex Hospitals NHS Foundation Trust catchment area. This was with the intention of recruiting greater membership to the Trust and has also had the benefit of gaining feedback on the Trust Services. It was planned to produce a short video about the benefits of membership of the Trust which could be used on the video loops which many Surgeries have.

7.2 The Membership Committee had also been focused on trying to achieve a more representative membership by recruiting more people in the 17-59 age group, more out of area patients and more minority groups.

7.3 It was noted that the Committee had also given presentations to groups of volunteers based at the hospital in Worthing and hoped to do this at St Richards in Chichester in the near future. Other work had included making changes to the Membership Leaflet. Val Turner commented that the current leaflet asked for details of an individual's connection with the Trust but that not all local people might have one and therefore they may feel that membership may not be appropriate. Vicki confirmed that this would be changed in the next version of the leaflet.

7.4 Joanna Crane asked for confirmation of the current number of members of the Trust.

7.5 Post Meeting Note:
Public and patient plus staff governor numbers as at 22 Jan 2015 = 7547
Public and patient plus staff governor numbers as at 29 Aug 2012 = 7536
Quality and Risk Committee Feedback

8.1 Joanna Crane, Chair of the Trust Quality and Risk Committee (QRC) gave an update on the work of the Committee. She confirmed the purpose of the Quality and Risk Committee was to support the Board in ensuring that

- the Trust’s management of clinical and non-clinical processes; that controls were effective
- in setting and monitoring good standards
- and continuously improving the quality of services provided by the Trust.

8.2 Joanna confirmed that there was cross Division representation on the Committee with Chiefs of Service and Heads of Nursing attending which meant that the Committee was a useful place for wide ranging discussion on both risk and quality.

8.3 Joanna also confirmed that the QRC discharged its duties by:

- Considering the Quality strategy, targets and outcomes. This was achieved by receiving updates in the Quality Strategy and all CQC updates
- Considering Clinical governance, clinical audit and risk management including receiving the Board Assurance Framework and Risk Register (>12 pre mitigation)
- Focusing on patient experience with the Trust’s Patient Experience and Feedback Committee reporting to the QRC.
- Receiving regular updates from the Caldicott Guardian on Information Governance
- Receiving the Trust’s Patient Safety Incident Report and through the Serious Incident Requiring Investigation Panel reporting to the QRC.
- Reviewing all Efficiency and Transformation Programmes for quality impacts

8.4 It was also noted that a Non-Executive Director attended all Trust Quarterly Clinical Governance reviews.

8.5 Joanna confirmed that links with the Trust Audit Committee were maintained by the Non-Executive Director Lizzie Peers who was a member of both Committees.

8.6 A large focus of the work of the Committee was to look at the range and complexity of risks seen across the Trust and to ensure that they were suitably recognised. It was also noted that the Trust’s Risks were linked to the Corporate Objectives via the Board Assurance Framework.

8.7 Richard Farmer asked how the Board could provide information on the current risks within the Trust. It was confirmed that this could be discussed at the Joint Governor and Non-Executive Director Meetings or with members of the Executive Team for more specific information.

8.8 It was recommended that for future meetings of the Trust Patient Experience and Feedback Committee a report was received from the Governor Patient Experience and Engagement Committee to ensure a link between the two Committees.
MINUTES

9.1 Mike Jennings, Commercial Director gave a presentation on the findings of the Joint Impact Assessment of the potential award of the Muscular Skeletal Services (MSK) contract to BUPA CSH.

9.2 He confirmed that the aims of the Joint Impact Assessment included ensuring visibility to the Clinical Commissioning Group (CCG), the Trust and the Health and Social Care Committee (HASC) of all the impacts.

9.3 Mike outlined the key findings of the Joint Impact Assessment which included:

- There were a number of adverse clinical impacts that required mitigation.
- Financial sustainability of the Trust was threatened if the proposal went forward without mitigation. This would be between £2.7m and £10m per year.
- Over a 5 year contract even the £2.7m scenario would grow to a £13m cumulative impact by year five if unmitigated.
- These impacts may be compounded by increased difficulty in recruitment and retaining staff as the full range of Orthopaedic Services would not be available across the Trust making it a less desirable place to come and work.

9.4 Clinical Impacts which would be substantial if not mitigated included:

- A clear Orthopaedics pathway from outpatients to consent for any treatment being delivered by one person/team.
- Impacts on trauma configuration – case mix, emergency on call rota, volumes, sub specialisation.
- Impacts on services outside of MSK – availability of advice, acute patient contact.
- Impact on residual physiotherapy service.

9.5 Overall the conclusions for the Trust were that the procurement raised serious sustainability concerns if it went ahead unmitigated and it was noted that these in turn would threaten the configuration of services such as A&E. Mike also reminded the Council of Governors that the CCG had publicly assured that they would not sign a contract with BUPA CSH if local health services would be destabilised.

9.6 The Trust had been in continual dialogue with BUPA CSH, to determine whether an agreement could be reached that mitigated the clinical and financial concerns. It was also confirmed that the Trust would not sign a contract with BUPA CSH without clear contractual guarantees that mitigated concerns. To conclude his presentation Mike confirmed that the Trust continued to have the concerns of patients and the delivery of sustainable, high quality services, as its main priority.

9.7 Margaret Boulton asked about the expected case mix that the Trust would receive if the contract was awarded to BUPA CSH. Mike Jennings confirmed that assurance of the case mix would be included within any contract. Also an exit plan would be part of any contract.

9.8 Richard Farmer asked if there was any indication if the CCG would cease negotiations with BUPA CSH and Marianne Griffiths confirmed that they had indicated that they would not sign a contract unless that there was a guarantee that services would not be affected. BUPA CSH needed to
mitigate the areas highlighted within the Joint Impact Assessment.

9.9 It was confirmed that the Trust was keen to seek resolution to the award of the contract and was therefore seeking a final outcome before the end of February 2015. It was recognised that the current position was uncertain for staff.

9.10 Margaret Bamford reminded the Council of Governors that one of the primary objectives for the proposed changes within MSK Services across West Sussex was to develop clear joined up pathways for patients. Mike Jennings confirmed that this had been the focus of the bid that the Trust had been part of and that this bid could be resubmitted to the CCG.

9.11 To conclude the item Mike Viggers, Chairman thanked the Governors and members of the public for their support of the Trust over the MSK bid. The priority was to gain a positive outcome for the patients of West Sussex and the Trust.

**COG /1/15/10 Governors Strategy Group Feedback**

10.1 Paul Benson, Patient Governor presented an update from the Governors Strategy Group which had met for the first time in November 2014. He explained that the purpose of the group was to seek Governor’s views on proposed strategic initiatives and developments.

10.2 At the meeting an update on the strategic planning process including the requirements for Monitor was given along with reviewing the commissioning intentions from the CCG. The content and the implications of the Five Year Forward View were also considered along with ways to address the “classic divides” between health and social care, secondary and primary care, physical and mental health alongside prevention and treatment. Different models for future provision were discussed.

10.3 It was noted that a further meeting of the group would take place on the 27 January 2015 when the focus would be on reviewing the impact of national planning guidance.

**COG /1/15/11 Quality Strategy Development**

11.1 Dr Findlay gave a presentation on the development of the Quality Strategy for the Trust for the period 2015-2018 and confirmed that the aim was that as an organisation the Trust provided the best care every time. The key goals were:

- Reducing mortality and improving outcomes
- Providing safe care and reliable care
- Improved patient and staff experience

11.2 For the first goal Dr Findlay explained that the aim was for the Trust to be in the 20% of NHS organisations with the lowest risk adjusted mortality. He explained that despite an increasingly complex and elderly case mix the Trust had shown a continued improvement in crude non-elective mortality. The Key Quality Improvement Priorities for 2015 to 2018 included the implementation of care bundles to improve the recognition and care of deteriorating patients including sepsis, acute kidney injury and preventing cardiac arrest. There would be a focus on the implementation of the “Better Births” programme which included reducing
the number of interventions. There would also be further development of a programme of structured review of every death occurring in the hospital to ensure learning.

The focus of Safe Care would be to ensure that 100% of patients received safe, harm-free care as measured by the following harms:

- Pressure Ulcers
- Catheter Associated Urinary Tract Infections
- Venous thromboembolism
- Harm from falls
- Hospital acquired infections
- Prescription Errors

Reliable Care would focus on seven day services and ensuring that all new patients had a Consultant review within 14 hours of hospital admission. Also it was noted that a programme of work focused on improving patient experience would include:

- Night time care – reducing noise at night and ward moves which take place at night
- Increasing meal time support
- Improvement in communication with particular focus on the involvement of relatives/carers and discharge planning.

Dr Findlay outlined the next steps of the Quality Strategy which included a proposed Stakeholder Forum to gain feedback on quality priorities for 2015/18 and the Quality Account for 2014/15. He confirmed that the Quality Strategy would be published in June 2015.

The Council of Governors were also reminded that the Trust was required to submit a Quality Account to Monitor detailing the quality of care provided. The Trust would be required to have elements of data included in the report audited by external auditors. A number of indicators to be audited would be specified nationally and a further one would be selected by the Governors.

Val Turner asked about the use of electronic patient records and access to GP records in order to assist and possibly speed up treatment. Dr Findlay confirmed that electronic prescribing was being introduced across the Trust from February 2015 and staff already had access to summary care records. Over the last few months electronic discharge summaries had been introduced and were being used in 95% of cases. It was also confirmed that the Trust was also working towards having electronic patient records and that this should be fully implemented within the next three years. Overall over £3m had been invested in IT Infrastructure to enable these projects.

Shirley Hawkridge asked how IT could be used to assist early diagnosis of deteriorating patients and Dr Findlay confirmed that the Trust was an early adopter of Patient Track 2 which supported this aim. Dr Findlay did however remind the Council of Governors of the importance of manual observations and the particular information they gave.

Stuart Flemming asked for an update of the possibility of a LINAC being situated on the St Richards site in Chichester. Dr Findlay confirmed that discussions were continuing to take place with the Trusts based in Brighton and Guildford regarding this, but this was still the intention. A
Head of Terms agreement was currently being developed.

11.10 Vicki King referenced the statement in the presentation given to the Governor Strategy Group – “Bariatrics given as an example of money poorly spent”. Dr Findlay confirmed that although Bariatric Surgery could save money within Health Services in the long term for patients who were morbidly obese, funding could be better invested in Public Health, prevention and diet advice. Jane Ramage asked if problems were caused by numbers of bariatric patients attending St Richards for other conditions, and also what impact of any there would be on the Trust financially if the proposal to halve the tariff for bariatric surgery were implemented, as mentioned on a Radio 4 discussion the previous day. Karen Geoghegan confirmed that there was a national proposal to change the tariff received for providing Bariatric Treatment and she confirmed that the Trust had responded to the relevant consultation.

COG /1/15/12 Operational Plan Development 2015/16

12.1 Mike Jennings gave an update to the meeting on the development of the Trust’s Operational Plan for 2015/16. He confirmed that the plan would focus on considering new models of care and taking on Board the recommendation of reports such as the Dalton Review. Partnerships would be a key focus including greater out of hospital care across organisations.

12.2 The guidance for the Operational Plan included making sure that there was a strong emphasis on alignment with commissioner plans and ensuring resilience and sustainability. There would need to be a focus on achieving in-year financial, performance and quality targets. In terms of sustainability this would mean delivering themes within the Strategic Plan with particular emphasis on, Unscheduled Care, Surgical reconfiguration, Cancer Services, improvements at Southlands, securing appropriate commercial opportunities, Patient First programme and seven-day working.

12.3 To conclude the item Mike Jennings confirmed that a one year Operational Plan was required by Monitor to cover the period 2015/16 and that this would be submitted to the Trust Board for approval on the 2 April 2015. The Governor Strategy Group would represent the views of the Council of Governors and provide input into the operational plan and on-going strategic plan refresh.

COG /1/15/13 Proposal for Deputy Lead Governor

13.1 This item was deferred to the Council of Governors meeting due to take place in April 2015.

COG /1/15/14 Other Business

14.1 Richard Farmer commented on the current vacancy situation across the Trust and asked about the impact within the organisation. He also asked if the vacancy rate meant the Trust was saving money in terms of the pay costs. Denise Farmer confirmed that there were no financial benefits within Nursing or Medical staffing of the current vacancies rate as shifts had to be covered through Agency or Bank staffing in order to ensure safety. Also additional cover was required for sickness absence. Denise also confirmed that both short and long term actions were needed to ensure that the Trust was an employer of choice and therefore resolve
some of the vacancies issues.

COG /1/15/15  Questions from the Members of the Public

15.1 Hazel Thorpe – Worthing Borough Council
Hazel said that she was keen to express the support of Worthing Borough Council in regard to the Trust and the provision of MSK services for the patients of West Sussex. She asked how the Council could work collaboratively with the Trust with this regard.

Marianne Griffiths confirmed the Trusts appreciation and commended the public support. She however stated what was needed was to ensure that all risks identified within the Impact Assessment were mitigated in order to deliver the best possible care for patients.

15.2 Jim Deen – Worthing
Mr Deen expressed support for the Trust in trying to ensure the best care for MSK patients from West Sussex. He commented that he was keen to obtain a full version of the Impact Assessment – even if it had to be redacted. He asked about the likely plans going forward for the MSK services if the contract from the CCG was not awarded to BUPA CSH. Would the contract then go to the second place bidder and what would happened to ensure continuity of service?

Marianne Griffiths confirmed the intention of the Trust was to remain committed to rolling out improved services for MSK patients as soon as was practically possible. This could if appropriate include amending approaches from the partnership bid it was involved in when the final decision on the proposed award of the contract was made by the CCG.

15.3 Heather Duffield
Ms Duffield talked about concerns over the number of patients which were fit for discharge and asked if any extra funding was being made available from the CCG to facilitate patient flow.

Marianne Griffiths confirmed that the provision of correct packages of ongoing care for patients was a real concern which was affecting patient flow. She reminded that Council of Governors that staffing of community beds was an issue. It was confirmed that Sussex Community Trust was planning to open some further beds in Salvington Lodge in Worthing and in Bognor over the next week which would offer some further resilience.

15.4 John Wilton – Chichester
Mr Wilton asked for confirmation that it was expected that the cumulative loss of income for the NHS due to the potential award of the MSK contract to BUPA CSH would be in the region of £13.4m.

Mike Jennings confirmed that this was correct for the expected 5 year period of the contract.

15.5 Alison Evans
The place of surgery was highlighted as a concern with regard to the MSK bid. Would a patient who required a hip replacement as a result of a trauma be transferred to a private provider and what would happen with patients who had complications past surgery. Alison also raised concerns with regard to education issues, training and maintaining clinical skills. It was confirmed that these had been covered in Joint Impact Assessment.
If the MSK contract was awarded to a private provider what would the impact be in the event of a major incident? It was confirmed that this had not been part of the Joint Impact Assessment but would need to be considered.

If the contract was not achieved and waiting list climbed who would be responsible for meeting Referral to Treatment Time deadlines. It was confirmed that this would be the primary provider and not any subcontractor.

**COG /1/15/16 Date of Next Meeting**

The next meeting of the Council of Governors would take place at 09.30 am on Tuesday 14 April 2015 in Mickerson Hall, CMEC, St Richards

Barbara Mathieson
Assistant to Company Secretary
January 2015

Signed as an accurate record of the meeting

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<tr>
<td>COG/1/15/4.4</td>
<td>Update on Private Patients to be taken to a future COG Seminar/Briefing</td>
<td>AG</td>
<td>April</td>
<td>Date set 21st May 2015</td>
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<td>Provide information on the comparison of the Capital Investment at all three Hospitals</td>
<td>KG</td>
<td>April</td>
<td>Information sent by email on Thursday 2 April 2015</td>
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<td>COG1/15/5.13</td>
<td>Outcome from review of activity and resilience during December 14 and January 15 to be brought to future COG</td>
<td>AG/JF</td>
<td>July</td>
<td>Update to July Council Meeting when review completed.</td>
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<td>Report from Patient Experience and Engagement Committee to be taken to future Trust Patient Experience and Feedback Committees</td>
<td>AG</td>
<td>March</td>
<td>Completed on Agenda for the PEFC meeting due to take place on the</td>
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Date of Meeting: 14th April 2015

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<td>Chief Executive’s Performance Report</td>
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<th>Summary of Proposal</th>
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<td>The Chief Executive will update the Council of Governors on the performance of the trust over the past quarter in its strategic context, to enable a discussion by Governors on overall performance against targets and strategic objectives, and the performance of the board in leading the trust’s achievements.</td>
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The update will cover patient safety, patient feedback, activity, finance and workforce. The board has received detailed monthly reports on each of these areas, and these are available for governors on the trust’s public website.

At the time of writing the latest available performance data is to the end of February 2015. A verbal update on key items will be provided at the Council meeting on the final year end position.

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<th>Implications for Quality of Care</th>
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<td>Patient Safety and Quality of Care are covered in the presentation</td>
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<th>Link to Strategic Objectives/Board Assurance Framework</th>
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<td>The quarterly report demonstrates progress against all the strategic objectives</td>
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<th>Recommendation</th>
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<td>The Council is asked to: NOTE the report and ask any questions of the Executive Directors.</td>
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<th>Communication and Consultation</th>
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<td>The information included is publicly available and has been discussed by the board.</td>
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This report can be made available in other formats and in other languages. To discuss your requirements please contact the Company Secretary on 01903 285288.
FOR INFORMATION

PERFORMANCE OF THE TRUST to end of February 2015

1. INTRODUCTION

This paper sets out how the trust has performed since the last Council meeting, setting that in the context of the local and national picture.

Performance is reviewed monthly by the board in public, and these papers are available on the trust website for governors wishing for further background information.

I will update the Council on any key items that materialise between the writing of this report and the Council meeting, in particular with regards to our financial and performance position and the Monitor Risk ratings.

We once again have a busy Council agenda and I am delighted to welcome Marie Dodd, Chief Operating Officer, NHS Coastal West Sussex CCG.

2. OVERVIEW AND SETTING THE CONTEXT

The Council of Governors has previously been updated on the high level of activity within the Hospitals and the Trust declared two Business Continuity Incidents during December. Since that time activity has remained high and there have some occasional ‘pinch-points’.

Workforce remains a concern and I will talk more about this later.

2.1 Key indicators of operational pressure during February include:

- 9,462 A&E attendances compared to 9,703 in February 2014 (-2.5%). When scrutinised by age group: there was a -2.0% decrease in 65-84 years and a 0.7% increase in >=85 years February 2015 compared to February 2014.
- 4,060 emergency admissions compared to 3,672 in February 2014 (+10.6%). When scrutinised by age group: there was a 4.7% increase in 65-84 years and a 13.7% increase in >=85 years February 2015 compared to February 2014.
- Formally reportable delayed transfers of care totaled 3.68% for February 2015. This excludes patients who are medically fit for discharge but have not been classified as delayed transfers under national guidance following a multi-disciplinary case review.
- Occupancy of funded bed stock was 98.3% for February 2015.

From the above the Council will see that activity continues to increase and this is combined with a higher degree of acuity and frailty in admissions.
I wish to take this opportunity to thank all staff who continue to deliver great care in really challenging circumstances.

2.2 Musculoskeletal (MSK) services

Coastal West Sussex CCG has made the decision to stop the procurement for MSK services in the region. The CCG are actively talking with local providers, including detailed discussions with the Trust regarding delivering a lead provider integrated MSK service model for our population. Any further decision regarding a future procurement on MSK has been put on hold whilst these discussions take place.

If any further information becomes available I will update the Council when we meet.

3. QUALITY REPORT

The full Trust Quality report, together with its dashboard of indicators, is presented in public each month at the trust Board meetings. The dashboard is based on national and regional benchmarks where available. In the absence of established benchmarks, locally agreed targets or levels have been defined.

The highlights from the February reporting data are as follows;

3.1 Mortality

The Council have previously been advised of the improvements made in crude mortality rates which have fallen year on year from 3.60% in 2010/11 to 3.22% in 2013/14.

Crude non-elective mortality fell slightly in February from 4.24% to 4.22% but remained higher than the equivalent month in 2014 (February 2014 = 3.83%).

The 4.22% mortality in February related to 212 deaths out of a total of 5024 non-elective admissions.

This increased rate over winter (December, January and February are all above levels for 2013/14), co-incided with the extreme pressure caused by increased admissions for very elderly patients (over 85) and extreme pressure on beds. At the time of reporting, mortality in March has fallen to 2014 levels. Following the raised mortality rate over winter, it is likely that the Trust will report a modest increase in mortality for 2014/15.

The increased mortality rate this winter is a phenomenon that has been noted nationally in publications by The Office of National Statistics.

3.2 Stroke Care

Nationally stroke care is measured by the Sentinel Stroke National Audit Programme (SSNAP). Trusts are measured at site level for compliance against six domains (acute care; specialist roles; interdisciplinary services; TIA / neurovascular clinic; quality improvement, training and research; and planning and access to specialist support). Each trust site is given an overall score: a letter from A to E (with A being the highest).

Data has now been published for quarter 3 (October to December 2014). In the latest data, St Richards improved from a grade D to a grade C. Worthing also maintained its overall grade of C. For context, of the 204 Trust teams in
England and Wales 86 (42%) were graded C or above, 89 (44%) were graded D and the remaining 29 (14%) were graded E.

3.3 Tissue Viability

The number of pressure ulcers in the Trust has fallen over recent years from 283 in 2010/11 to 105 in 2013/14. An internal limit of 100 cases grade 2 hospital acquired pressure ulcers has been set for 2014/15. This is based on a 5% reduction against the actual number in 2014/15. The limit for grade 3 and 4 ulcers has also reduced from 4 to 2.

During February the Trust reported 8 cases of hospital acquired pressure sores (Grade 2). This was against an in-month trajectory of 8. The Trust remains on course to achieve the target for the year.

There were no hospital acquired grade 3 or 4 pressure ulcers in February.

4. PERFORMANCE REPORT

Based on Month 11 positions, Quarter 4 is projected to score 2 points against the Monitor Risk Assessment Framework performance metric set. Both penalty points related to planned non-compliant in Referral to Treatment (RTT) linked to agreed recovery plans.

The Council will be aware that following a dip in performance the trust is working hard to achieve its A&E target and at the time of writing we are projected to do so.

The Trust had 1 case of C.difficile in February, giving a cumulative total of 36 in the 11 months of the year to date, set against a revised target of no greater than 56 cases for 2014/15.

Due to the RTT performance issue highlighted above the trust remains 'Under Review' in terms of its Governance risk rating with Monitor.

4.1. A&E Compliance

The Trust was compliant in February with 95.73% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge, against a national target of 95%.

For context and comparison, national data for the period 2nd February to 1st March relating to Type 1 (Major A&E) departments shows compliance of 87.7%. Compliance for Surrey and Sussex Area providers (excluding WSHFT) for the same period shows 89.6% for Type 1 A&E attendances, with Western Sussex Hospitals being the second highest performer within the sector.

A&E performance as at 23rd March is 97.33% for the month. This generates a cumulative position for Quarter 4 to date of 95.59%, and underpins a compliant forecast for the period. I will be able to provide an update to this position at the Council meeting.

4.2 Referral to Treatment (18 Weeks)

In February the Trust completed 10,316 RTT pathways, 16.0% more than February 2013/14. In the 11 months of 2014/15 to date the Trust has completed 18.9% more RTT pathways than the previous year, being the 11th
largest annual step increase in England and the 3\textsuperscript{rd} largest annual step increase for Trusts in the South Region.

There has been a slight increase in the total elective waiting list from 31,931 in January to 31,106, and in year waiting list growth stands at 10.1% since April 2014.

In January the Trust completed 11,015 RTT pathways, 16.1\% more than January 2013/14. In the 11 months of 2014/15 to date the Trust has completed 18.9\% more RTT pathways than the previous year, being the 11\textsuperscript{th} largest annual step increase in England and the 3\textsuperscript{rd} largest annual step increase for Trusts in the South Region. While there has been a slight decrease in the total elective waiting list from 31,511 in December to 30,931 in January, in year waiting list growth stands at 10.1\% since April 2014.

Continued imbalance in demand and available capacity continues to commit the Trust to recovery actions and associated non-compliant in all three metrics relating to Referral to Treatment (RTT).

Detailed weekly specialty recovery trajectories have been developed and submitted to Monitor. Emergency pressure on beds has triggered unavoidable cessation of elective inpatient work to ensure patient safety and impinged on delivery as planned. Non-elective pressures on beds in Quarter 4 2014/15 are anticipated to extend into Quarter 1 2015/16, elongating the planned elective recovery period and compromising restoration of aggregate compliance by the end of Quarter 2 2015/16.

Contingent on controlled growth in referrals, increased access to community support for patients fit for discharge, and contractual agreement to support recovery plan volumes, compliance would be recoverable by the end of Q3 2015/16. However, extension of elective recovery into Quarter 3 enhances risk due to seasonal increases in non-elective patterns. As such, the scale of recovery requirement and inherent risks relating to demand will generate a need for continuous monitoring and refinement of recovery actions and associated timeline for return to compliance in 2015/16.

As part of the recovery planning process, the 18 week Intensive Support Team (IST) has been engaged with the support of Monitor and NHS England to help validate Trust plans and provide external assurance. The resulting 18 Week IST/IMAS assurance review of WSHFT has been undertaken, and initial verbal feedback from the IST review team confirms robust governance and delivery processes at the Trust. Formal written feedback is due in the first week of April 2015.

5. ORGANISATIONAL DEVELOPMENT AND LEADERSHIP REPORT

The impact of the on-going high levels of activity on our staff continues to be a cause for concern. As does the problems locally and nationally with recruiting qualified nurses.

A new Workforce Transformation programme is being developed under the auspices of the Patient First Programme Board to help identify and deliver opportunities to bridge the current gap.

The Council will receive a separate report and presentation on the outcome of the Staff Survey and other key workforce items as part of the Councils agenda.
5.1 Workforce Efficiency

As anticipated, sickness absence deteriorated further in month to 4.9%, with a 12 month rolling sickness rate of 4% at the end of January (February data not available at the time of writing).

Short term absence increased across all Divisions with the average duration of absence increasing from 4.7 days in December to 5.5 days in January.

Sickness absence during February is expected to improve although as previously noted, the end of year outturn position will be higher than last year.

5.2 Recruitment Activity

A recent local recruitment campaign for registered nurses has attracted over 30 applicants, with an open selection day on 25 March. A verbal update on the success of this day will be made to the Board. Learning from the day will be incorporated into the 6 week rolling recruitment programme.

The international recruitment campaign (to the Philippines) is progressing well.

5.3 Communications and Engagement

Patient First Programme

A further Patient First Workshop was held on 19 March at the Chatsworth Hotel, Worthing for a cross section of 60 Trust staff. Initial feedback has been very positive and comments include; “Thoroughly enjoyed - honored to be involved”, “great opportunity to think about Patient First in my department and how to lead on this”. A further two workshops are planned in April and a more detailed evaluation report will be provided then.

National Apprentice Week

Three of the Trust’s apprentices, Matt Woolgar (Facilities), Jenna Vincent (Sexual Health) and Dean Wells (Pharmacy), won awards at the Health Education Kent, Surrey and Sussex awards on 9 March. The Trust was also runner up for the Apprentice Employer of the Year award. The Trust also celebrated National Apprentice week with two afternoon tea parties for apprentices and their managers.

6. FINANCE REPORT

The Trust reported a deficit of £0.8m in February, bringing the cumulative deficit in the year to date to £2.46m. The reported position in February is in line with the forecast for the month and the revised year-end surplus of £0.3m remains deliverable providing the risks identified at 6.5 below are mitigated. The CoS rating remains at a 3 at the end of February and the forecast rating for the end of March is a 3.

I hope to be able to advise the Council at our meeting as to the final year-end position with regards to our Continuity of Services rating.
6.1 **Surplus position**
Significant over-performance in non-elective activity continued in month, and although operational pressures continued to be experienced by the Trust the elective cancellations were fewer than in January and day case activity was maintained. Pay costs were close to plan with reductions being seen in Medical and Agency pay from efficiency plans that are starting to deliver. Non pay costs were high in Clinical Services due to increased orthopedic activity but were partially mitigated by non-recurrent benefits in corporate areas.

6.2 **Income**
Non elective admissions remain high during February, however movement towards a reduced run rate has been observed in month. Elective orthopedic admissions have increased in month above run rate with the remainder of elective activity maintaining levels of activity and income consistent with run rate in month 10. Income to date is £6.6m above plan. Total income for the year is forecast to be circa £390m.

6.3 **Efficiency and Transformation Programme**
Firstly I would like to say just how much has been achieved this year. It has taken a significant focus and robust programme management to deliver what we have. We have never delivered the level of savings that we have this year.

For the year to date, savings of £14.3m have been delivered, being 85.0% of Plan. The in month position has been driven by under-performance in a number of work-streams compromised in part by operational pressures. Forecast outturn savings has reduced by £0.2m to £16.9m.

Delivering savings of an equal size in 2015/16 will be a significant challenge.

6.4 **Continuity of Service Rating (CoSR)**
The Trust continues to report a Continuity of Service Rating (CoSR) of ‘3’.

6.5 **Key Financial Risks are;**
At the time of writing the key risks are shown below. However, we shall have greater certainty on some of these by the time we meet.

(i) Performance against operational budgets and delivery of agreed control totals. Ability to flex cost base appropriately to take account of activity changes. Ability to manage patient flow to reduce escalation capacity to planned levels.

(ii) Delivery of forecast savings within the efficiency programme.

(iii) Completion of the Trust Estate rationalisation programme.

7. **CONCLUSION AND RECOMMENDATIONS**
The Council is asked to NOTE the report and ask any questions.
To: The Council of Governors  
From: Margaret Bamford, Lead Governor

TO RECEIVE

REPORT FROM LEAD GOVERNOR

1. **Introduction**
Governors continue to contribute actively to the work of the Trust, playing a full part in ensuring the views and the wishes of the community are represented accurately at all levels of Trust activity. They have continued to refine processes for seeking assurance from Non Executives about Board performance and participated in a wide range of initiatives, committees and work groups.

2. **Governor Elections**
On the advice of NHS Providers, governor elections due to be held in May/June have been postponed until after the General Election to avoid any party political controversies. When the Trust was established governors were elected for 2 or three 3 year terms to ensure that the whole group did not change at the same time. Staggering elections provides for continuity and stability. New appointments will be announced on 28th August. Between now and then governors will consider how best to manage the transition and ensure newly elected governors are adequately supported.

3. **Governors Nomination & Review Committee**
   - Recommendations have been implemented to adjust HR processes to take into account the explicit role of governors involved in the appointment of NEDs. The last NED appointment used the new process and worked well.
   - Governors have been involved in setting and agreeing the annual objectives of the Chair and will shortly be contributing to the review of his performance.
   - The Committee has reviewed the Trust’s Code of Conduct for governors. Suggested revisions will be brought to the next Council meeting. A process for managing non-compliance has been drafted and is in the process of final consultation. It too will be brought to the July Council meeting.
   - The issue of the appointment of a Chair was considered and a recommendation will be considered at the full meeting of Council.

4. **NEDs/Governors Assurance Meetings**
These bi-annual meetings provide an opportunity for governors to seek assurance from Non-Executives that they are challenging appropriately the Executive Board on its performance. As governors implement their role more extensively they meet more members, patients and the public and are able to identify more accurately their concerns and represent them to the Board. The key issues for this quarter were:
   - **Staffing:** Governors were reassured by the range and robustness of measures, including a careful review of HR processes, to address shortages across nursing and some medical specialities. Difficulties in nursing have been well publicised. Expenditure on bank and agency was up £2m+ on last year, with market shortages and sickness contributing to a
2,000 vacancies across the region. Governors noted that NEDs are well informed and support the Executive in tackling what have long been regarded as intractable problems and that the measures have begun to yield positive results.

- The CCG’s MSK procurement exercise. What was learned and what might be done differently next time? With the benefit of hindsight the Trust should, before submitting their bid, have seen the impact assessment requested from the Area Team. This was made available to the CCG. While the Trust was confident that their bid represented an improved and joined up service which would have made things significantly better for patients, it had also been realistic and taken into account the needs of the whole patient constituency. The Trust was aware of the significant risk to the Trust of not being successful but considered their approach had mitigated that risk. Governors are reassured that the current collaborative approach to the improving the care pathway with the CCG represents the best way forward for patients

- Ophthalmology Services. How are NEDs seeking assurance from the Executive that what is being done is effective? Is there a regular reporting/monitoring process – to whom and at what intervals? Are patients being involved? Are patients receiving information about the situation? Non Executives confirmed they were very aware of the volume of complaints about this service – approximately 17% of all complaints. The reasons had been well rehearsed in other forums (changes to the commissioning criteria, an exponential increase (440 – 650 per month) in referrals, difficulties in recruiting experienced staff, and administrative processes in need of updating.) The Improvement Plan developed by the Executive was presented to the Board sitting in public recently. It appeared thorough and achievable. Although it is early days there have already been a number of plaudits from patients who have commented on the improved service, and in the meantime the Non Executives are monitoring and seeking regular reports on progress

- Referral to Treatment Targets. As the Trust remains non-compliant with all three metrics Non Executives have requested a bed profiling review to test whether there needs to be rebalancing between elective and non-elective surgery. Governors are aware that a late cancellation of planned surgery causes distress and inconvenience. While it was understandable during the business continuity crisis, it is not acceptable routinely. They are reassured by the NEDs awareness and actions.

- Finance. There is not enough money in the system to fund current demand and activity. Where the deficit should be located between the CCG, the SCT and the Trust is unclear. The hospital cannot close its doors; the SCT closed 42 beds last year, which seriously compromised the Trust’s capacity to discharge safely into the community and at one point resulted in just over 180 delayed discharges across the two sites; and activity has continued to outstrip CCG commissioned, budgeted activity. The Trust will achieve its cost improvement targets this year in excess of 4% but next year’s savings target is extremely challenging. Western is one of the Trusts having sought uplift to tariff but as yet there is no indication of the possible outcome. Governors will continue to support pressure from the Trust to secure an appropriate financial settlement

- Redacted Board minutes are appreciated but it is early days to consider how useful they are for governors in creating greater transparency of Board business than already exists.

5. Patient Experience and Engagement Committee
This Governor led Committee continues to meet quarterly bringing together the CCG’s community based patient GP practices, participation groups from HealthWatch, and governors. The Terms of Reference have been agreed by Council and are directly aligned with the role of governors, namely seeking views of members, the public and statutory bodies to inform priorities for the development of future strategies and work improvement programmes.
There have been some challenges in establishing the group as fully operational and efficient. Difficulty with dates, sickness and thinking through how best to establish a feedback link with the Trust’s Quality and Risk Committee and the Patient Experience and Feedback Committee, have exercised minds. Governors believe that these have now been addressed. Dates have been set to the end of the year, and the presence of a Non-Executive (Deputy Chair of the Board) and the Director of Nursing will ensure a direct three way communication link.

In this quarter, as part of the Patient First Improvement Initiative, governors have been reassured by the concentrated effort that has been invested in improvements to the ophthalmology services and the response of the Executive to the numerous concerns expressed about out-patient services. They are pleased that two governors (John Todd and Jane Ramage) will be involved in the appointment of an external consultant to undertake a comprehensive diagnostic assessment of all the areas of concern. This is a major piece of work which needs to be undertaken systematically with due regard to the range and complexity of the issues involved.

Governors participated in two Stakeholder public consultation events held in Worthing and Chichester in January and March. These round table/ small discussion groups felt like genuine consultation on the 3 year Quality Strategy 2015 – 2018. Discussion was animated and constructive. The discussion, in Worthing, on ‘saving lives and improving outcomes’ was particularly helpful. The clear message was that saving lives should not be at ‘any price’ and that sensitive management of end of life care was just as important. The Trust responded to this immediately and at the second meeting introduced proposals for patients and their families to express their wishes and preferences for their care – including as they reach the end of their lives. Governors commend the Executive teams for this excellent initiative and will be monitoring implementation carefully.

All governors are concerned by the recently published report from HealthWatch on ‘Unsafe Hospital Discharge’. While the report concerns small numbers and is written in the context that ‘most discharges work well’ the anecdotal examples it quotes are very worrying. Same day readmissions are of particular concern but so are the absence of discharge assessments, lack of care plans on discharge, no involvement with relatives/friends, medication difficulties, and others. Hospital Discharge has been an issue of concern for at least 30 years but there still seem to be problems in standardising systems and processes to ensure smooth and safe transitions. Governors have agreed that this is an issue which needs to be pursued and will be requesting a report from the responsible Non Executive at the July meeting of Council.

Involvement in ‘Sit and See’ observations and PLACE inspections continue to provide direct evidence of the patient experience and can be an invaluable source of learning for staff leading to improvements in patient care.

6. Board meetings
Monthly Board meetings held in public, alternately in Worthing and Chichester are an effective way of ensuring that the business of the board is discharged with due diligence. Performance and Quality matrices are examined in detail with exception data being immediately evident. Regular statutory reports are presented with full supporting data. Attendance as a member of the public is an invaluable way of observing the Board at work and noting the way in which Non-Executives explore areas of concern with the Executive and seek assurance that remedial action is in hand. Governors are of the view that this is a high performing Board which well merits that accolade.
7. **Induction Pack (working Group JT AL)**
I am grateful to John Todd and Alison Langley who have been working with the able assistance of Barbara Mathieson to produce a pack for new governors. We have also had the benefit of a newly appointed governor (Brian Hughes) who will provide the first consumer feedback!

8. **Activities to which Governors have contributed**
There is never any shortage of offers from governors to contribute to the work of the Trust or to represent us in a variety of forums. I listed last time all the work groups in which there was significant governor involvement. In this quarter governors have been involved as follows:
- National Policy Forum: Vicki King – awaiting results of application
- Inaugural National Conference: Helen Dobbin and John Todd later this month
- Charitable Funds: Abigail Rowe
- Medical Revalidation and appraisals Barbara Porter/Paul Benson
- Kent Surrey and Sussex Awards: Paul Benson
- Monitor’s Quality Accounts: All
- Strategy Group: Richard Farmer and colleagues Barbara Porter, Helen Dobbin, David Walsh, Alison Langley, Beda Oliver
- KSS Awards: Paul Benson
- Membership Drive in Chichester: Stuart Fleming with support from his son(!), and governors - Jennifer Edgell, Nigel Peters, Vicki King, and myself.
- Volunteers induction talks: Shirley Hawkridge, Jennifer Edgell and Vicki King
- Business continuity: during the crisis a number of governors stepped in to support in practical ways including Barbara Porter, Stuart Fleming, John Todd, Vicki King, Shirley Hawkridge

9. **Membership Committee and Accountability Working Group**
Vicki King and Richard Farmer continue to do sterling work on these committees and will report separately.

10. **Conclusion**
Governors continue to appreciate the degree to which the Executive and Non Executives have worked with them to secure systems and processes of accountability which are clear and robust. They continue to be impressed by the Trust’s commitment to providing the highest quality of care for patients, and for their openness and transparency when things don’t go as well as hoped.

Margaret Bamford
Lead Governor

MB/mydocs/WSHFT/CoGLGs report 14.04.15
REPORT TO COUNCIL OF GOVERNORS FROM MEMBERSHIP COMMITTEE

14 APRIL 2015

The Membership Committee met on 18th February, the Council is asked to endorse the activities of the committee and in particular the Membership Strategy 2015-2018.

MEMBERSHIP STRATEGY 2015-2018

The Council’s attention is drawn to the main points of the Strategy which are;

- objectives and targets (membership numbers, representative index, details of members interests engagement levels and monitoring)
- target groups – men, under 60s and non-white British groups
- approach – more involvement of members in events, surveys etc.
- raising engagement of Members – different categories of membership – gold, silver and bronze plus a group of highly active members the “Foundation 500” plus Members microsites and a Members bid scheme.
- Communication and evaluation and review

NEW MEMBERSHIP LEAFLET

The leaflet is now redrafted with the strap line changed from “Join Us Now” to “Your hospitals, Your Care, Your Say”. It also has less text and we believe a clearer message about membership. The redrafting of the leaflet will be an on-going process in view of the changes outlined in the Membership Strategy.

RECRUITMENT INITIATIVES

WSHFT MEMBERSHIP POP-UP SHOP - Six Governors spend the day outside the Assembly Rooms in North Street on Friday 6th March talking to the passing public about becoming Members of the WSHFT. With thanks to Stuart Fleming for organising and his excellent shortbread, we offered them a hot drink and homemade biscuits as an inducement! As a result we collected 50 completed membership forms and handed out many, many more with promises from the busy people to complete and post them when they got home. Several people wanted to tell us about their or their family members experiences of the health services at St Richards and these have been collated and passed on to PALS and the PEEC.

GP SURGERIES – the visit to Flansham Park Surgery resulted in 16 completed membership forms and many more given out. The practice manager suggested putting a powerpoint presentation on their TV screen in the surgery with information about the Trust membership plus how to contact Governors. This is now up and running and at her suggestion we are in contact with the CCG Comms Officer to provide a slides for all GPs in West Sussex.
OTHER ACTIVITIES – these include a presentation to St Richard hospital volunteers, distribution of membership leaflets at Chambers of Commerce, Worthing Women’s Aid, the CAB and a local MP surgery, all resulting in recruitment of new members.

Compiled by Dr V King on behalf of the Membership Committee, April 2015
Introduction

Having achieved Foundation Trust status in July 2013, Western Sussex Hospitals NHS Foundation Trust (WSHFT) is answerable to its members. A responsibility of all foundation trusts is to recruit, communicate and engage with members as a way of ensuring service provision meets the needs of service users.

A Trust Member\(^1\) can be any member of staff, anyone who has been a patient or carer within the trust since 1 January 2010 or anyone who lives in any one of the five local authority areas covered by the Trust’s catchment; Adur, Arun, Chichester, Horsham or Worthing. Members are aged 16+.

Members can:
- Seek election as a governor
- Vote in governor elections
- Participate in surveys and consultations
- Attend trust events
- Influence the development of improvement plans, projects and new initiatives.

Aim

The Trust aims to recruit a substantial and representative membership base that is actively engaged in working for the good of the Trust.

Objectives

Currently the Trust has 7,302 public members, 6,291 staff members (staff are automatically members unless they have chosen to opt out) and 241 patient members. There is no data currently on the level of engagement for the membership base as a whole or individual groups within it.

The objectives of this membership strategy are:

\(^1\) There are few exclusions, but anyone who is a vexatious complainant, who has been dismissed from employment with the Trust or who has been involved in a serious incident of violence at the hospitals or against Trust employees or volunteers in the last few years would not qualify.
● To increase the number of public members by 5% year on year from a 2014 baseline and maintain staff and patient member numbers.
● To represent all groups\(^2\) with an index figure of at least 80 to 120 to ensure a representative balance of the membership\(^3\)
● To collect information on new and existing members in a way that records their areas of interest and expertise to allow for targeted engagement. The Target is **10% in year one and 15% in year two** with a continual drive for better data.
● To increase engagement levels of members in line with the national average of **10% of staff members, 14% of public members and 16% of patient members** deemed to be “active” members.
● To monitor engagement levels through annual surveys and by tracking response rates to in-year activity. Collect data for **100% of communications and activities**.

**Target groups**
The current level of membership is already in line with the national average, but the trust is keen to achieve membership levels of two per cent (8,950 people) of the public, 95% (5,700 people) of staff and one per cent (300 people) of “out-of-area” patient members.

The current membership is not entirely representative of the community it serves. At the moment, women are over-represented and men are under-represented. The number of white British members accurately reflects the composition of the Trust’s catchment population, while all other ethnic groups are under-represented and those aged 60+ are over-represented, while all younger age groups are under-represented, particularly the 16-30 age group.

In order to make the Trust membership more representative of the community the Trust serves, the particular target groups are:

- Men
- Under 60s
- Non-white British groups

Recruitment in these groups will be done alongside growing a generally more engaged membership across all groups.

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\(^2\) To represent all groups by age, ethnic group, disability or special needs, constituency.

\(^3\) The representation indexes compare the percentage of membership with the percentage of the base population. Numbers from 80 to 120 are deemed representative. For example if 10% of membership was 40-49 and 20% of base population was 40-49 the representation index would be 50, because 10% is 50% of 20%. Or if 60% of membership was Female but only 50% of base population was female the index would be 120 because 60% is 120% of 50%
Approach
Recruitment of members since 2013 has already been successful. The number of members is in line with the national average and some steps have been taken to capture data that will help with targeting of information and engagement.
With such a valuable resource available, the challenge for the Trust now is to use the membership base for the good of the Trust and get members more involved in:
- consultations and surveys
- influencing development plans
- sharing their experiences to help identify areas for improvement
- attending events
- representing the Trust at events
- seeking election (number of candidates for governor election is a good indicator of how active the Trust membership is).

A more active membership should become self-perpetuating as the Trust is able to draw from more examples of how members have driven change and through existing members recruiting new members from their social circles.

So the approach for the next three years is to continue to recruit members from under-represented groups, while increasing the engagement and activity levels of existing and new members.

There will need to be close working with the Patient Experience Committee (PEC) which will help inform topics for surveys and consultations. The results of engagement will also be shared with the PEC.

Balancing representation
The Trust will balance the representation of different groups by targeting the specific groups outlined above, while working to increase engagement levels among existing members.

- The Trust will target men though sports clubs, DIY stores and leisure centres and gyms.
- The Trust will target younger age groups through chambers of commerce, NHS Careers events, visits to Mother and Baby clinics and through 6th form colleges.
- The Trust will target minority ethnic groups through the Trusts BME Network and through contact with faith communities and partnership with local authority community development staff.

Becoming a member
Staff are automatically members unless they opt out. People who want to be public or patient members can sign-up online or by post. Membership forms are distributed around the hospitals
and at Trust events, while the website hosts a wealth of information on what membership means, along with an online membership form.

**Membership register**

It is a statutory obligation for all Foundation Trusts to establish and maintain a register of members.

The Trust’s existing membership register has the capacity to be used for better targeting. It has the ability to enable the Trust to record areas of interest for each member and to improve engagement.

Effective use of the register of members will be key to the development of engaged members, therefore a key activity for this strategy period is to fully analyse the information that is currently held about members and how it is used to target the information the Trust sends them.

**Raising engagement levels**

Generating higher levels of membership engagement is a challenge shared by all Foundation trusts. The Monitor report “Current practice in NHS foundation trust member recruitment and engagement”, includes case studies and examples from Trusts that have come up with innovative ways of addressing it.

In broad terms, these include:

- offering different levels and categories of membership, e.g. bronze, silver and gold or, as in the case of University Hospitals Birmingham thought, time, support and energy donor members.
- using communications channels to highlight the difference members have made to inspire others to have their say and get more involved.
- Creating a limited number of highly active members - e.g. the Stockport Foundation 500 for members who have the highest levels of influence and activity.
- Membership microsites - dedicated members-only sub-sections of the website that provide relevant information in one place, including events calendars, videos, forums, blogs and polls.
- Members bid scheme - e.g. the south London and Maudsley NHS Foundation trust - all trust members can bid for up to £750 for schemes that offer improvements in service user experience, mental health wellbeing and/ or social inclusion in their local community. Funded projects have included a sailing course for service users, sponsored coffee mornings, and early support “memory service” for people with dementia, theatre groups, gardening initiatives and many more.

**Methods of communication and engagement**

The Trust already employs a wide range of communication methods to communicate with the general public and, specifically to members. These include:
● media relations - for stories about the Trust to appear in local media
● Internet - the Trust has recently replaced its website with a more user-friendly version
● Email - the Trust emails individuals and groups with relevant information
● Newsletters - The Trust has a staff newsletter as well as a members newsletter
● Information seminars - the Trust provides regular briefing on specific areas of healthcare that are available for members to attend under the banner “medicine for members”
● Membership packs - on registration as a member, the Trust sends out a membership pack

Evaluation and review
The membership strategy will be reviewed annually against the objectives outlined above.

Key indicators to measure are:
● Number of members in each group (public, staff, patients)
● Percentage of members for which we have tracking and areas of interest information
● Percentage of members deemed to be “active” members. Active members will be classed as any member that has participated in more than one membership activity)
● Response to annual engagement survey.

Author: Membership Committee, Western Sussex Hospitals NHS Foundation Trust
Date of next review: June 2016 at the Council of Governors
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS – DISCHARGE OF RESPONSIBILITIES

HOLDING NEDs TO ACCOUNT - WORKING PARTY REVIEW - MARCH 2015

Introduction

On 15 April 2014, Council approved a framework developed by a working group of governors, for holding NEDs to account in accordance with Council’s statutory role. (In simple terms, Council has a statutory role in ensuring that the Board works effectively.) This was followed by an implementation plan agreed by Council on 17 July 2014.

The framework also encapsulates how NEDs and governors can work together to exchange ideas and concerns to improve the performance of the Trust as well as meeting Council’s statutory duty. A copy of the framework and implementation plan is appended.

At the Council meeting on 25 January 2015, governors agreed to reconvene the working group to review progress and achievements.

The Governors on the working group are: Paul Benson, Richard Farmer, Stuart Fleming, Vicki King and Beda Oliver.

Review by working group

The review comprised the following elements:

- Working group meeting 18 March 2015
- Meeting with Company Secretary and Lead Governor on 19 February 2015 to understand better the range of reports produced by the Trust with particular reference to information provided to governors on Performance
- Information on how the Council of University Hospital Southampton NHS FT discharges the accountability role
- Content analysis and comparison of the respective agendas of WSHFT public Board Meetings and those of Council, coupled with the CE’s Report to Council.

Results of review

1. Much progress has been made:

- The level of contact between NEDs and Governors is high
- We have transparency on NED objectives
- We now have redacted minutes of private sessions of the Board meetings
- We have NED representation on governor sub-groups PEEC, and pre-CoG meetings
- We have governor representation on some Board sub-committees
- Governor seminar sessions are in place
- We have six monthly meetings with all the NEDs, CE and Chair drop-in sessions and we have the monthly post Board briefing.
• Presentations to Council by NEDs

2. We are unsure about outcomes with regard to implementation of amendments to documents to highlight and reinforce the NEDs’ accountability role. It may therefore be helpful if governors are provided with a note confirming the actions which have been taken e.g. the introduction of ‘SMART’ objectives in the appraisal of NEDs.

The GN&RC is due to undertake a review of NED recruitment documentation. (Mike Rymer, latest NED, could be asked to relate his recruitment and induction experience.)

3. We looked at what standard scheduled information, essential to our accountability role, we feel may be missing from Council agendas (and from the Forward Look document). We compared the coverage of public Board meeting agendas for the last year with Council agendas and also considered the scope of the CE’s reports to Council. This enabled us to identify possible gaps.

We appreciate governors already receive all the public Board papers but felt there may be essential topics in those documents which might need to be carried over and covered explicitly in the agendas of Council meetings or incorporated in the CE’s reports. Our intention is not to ‘over engineer’ the role, duplicate information already available, add to the already heavy administrative burden of the Trust or damage relationships between governors and the Board. There are very simple ways of including topics which governors regard as essential to their role of understanding the Board’s effectiveness e.g. by use of ‘executive summaries’ and including a paragraph or section in the CE’s report. Dedicated web pages can also be set up. The key point is identifying what topics in relation to our responsibilities and WSHFT need to be on Council’s agenda.

Some examples of such topics are: Monitor targets and ratings, annual complaints, Board Assurance Framework*, Equality and Diversity, Quality, estates strategy, risk management. Additionally, we believe that benchmarking metrics would be useful.

Such reports can be added to the Forward Look document.

A possible way of extracting essential and relevant information from Board papers, instead of relying on self-search by governors, might be for particular governors to report back to Council on particular Board topics e.g. Quality.

4. Contact with NEDs is immensely valuable and has increased in the past year.

We may wish to consider other ways of improving our understanding of the NEDs role e.g. by requesting feedback from NEDs on particular issues and by sitting in on sub-committee meetings chaired by NEDs.

Next steps

• Discuss at Pre-CoG meeting on 31 March 2015
• Report to Council on 14 April 2015

* This is a document that sets out strategic objectives, identifies risks in relation to each strategic objective along with controls in place and assurances available on their operation.
Appendix - Framework for Holding NEDs to Account

Pre-requisites

- Council and NEDs should be aware of their respective roles and responsibilities through role descriptions, induction and training.
- NEDs' responsibilities should be reflected in their corporate and personal objectives and in the appraisal process.
- Reports from the Board as set out below should provide assurance that the board is setting strategy, controlling the trust, establishing the right culture and delivering accountability, in the following key performance areas:

Performance of the Board of Directors

Key areas of partnership and enquiry, in which governors can work with the Board to review trust performance and exchange ideas on the ways in which quality and patient experience can be improved. Governors can of course ask questions and seek clarification at any time on any of the items outlined below.

List of abbreviations in table:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF</td>
<td>Board Assurance Framework</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>F&amp;IC</td>
<td>Finance &amp; Investments Committee</td>
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<tr>
<td>FBC</td>
<td>Financial Business Case</td>
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<tr>
<td>OBC</td>
<td>Outline Business Case</td>
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<tr>
<td>OD</td>
<td>Organisational Development</td>
</tr>
<tr>
<td>PEFC</td>
<td>Patient Experience and Feedback Committee</td>
</tr>
<tr>
<td>QRC</td>
<td>Quality &amp; Risk Committee</td>
</tr>
<tr>
<td>SIRI</td>
<td>Serious Incident Review Investigation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Actions by Governors</th>
<th>Relevant Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational and financial</td>
<td>• Reviewing and seeking assurance on the Trust’s financial performance report from the chair of the F&amp;IC</td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>• Reviewing the annual report and accounts and any report of the auditor on them</td>
<td>Monthly finance report</td>
</tr>
<tr>
<td></td>
<td>• Reviewing and seeking assurance on the accounts from the chair of the audit committee</td>
<td>CIP report</td>
</tr>
<tr>
<td></td>
<td>• Seeking assurance on the process undertaken from the audit chair in order for Governors to appoint the external auditor</td>
<td>Annual audit report</td>
</tr>
<tr>
<td></td>
<td>• Reviewing and seeking assurance questions on the trust’s performance from the chair of the QRC and other NEDs attending specific committees</td>
<td>Audit ctee auditor appointment proposal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly performance report</td>
</tr>
<tr>
<td>Performance Area</td>
<td>Actions by Governors</td>
<td>Relevant Documents</td>
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<tr>
<td></td>
<td>• Reviewing and questioning the performance of WSHFT against established performance benchmarks, agreed key operational and regulatory compliance indicators and stated objectives</td>
<td>Quarterly BAF and corporate objective reviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor risk assessment framework as reported on the Monitor website.</td>
</tr>
</tbody>
</table>
| Quality, safety and the patient experience | • Reviewing the quality assurance report and accounts including CQC assessments  
• Reviewing of the Quality and Operational Performance scorecards and associated reports and other matters which may arise which threaten the reputation and stability of the trust;  
• Discussions with NEDs on governor areas of concern including those raised by members and NED concerns raised but not yet addressed (or work in progress)  
• Discussion with chair of PEFC and SIRI panel on in-depth findings on complaints etc and assurance gained on lessons learnt and remedial actions taken.  
• Council identifying and prioritising what appear to be issues of board performance and providing appropriate challenge | CQC reports (would also include other regulatory visits)                                                                                                                                                                                                                                           |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Quality report                                                                                                                                                                                                                      |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Quality account                                                                                                                                                                                                                     |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | PEFC minutes (the ones that go to Board)                                                                                                                                                                                            |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Patient surveys (inpatient, outpatient, cancer etc)                                                                                                                                                                                   |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Monitor risk assessment framework as reported on the Monitor website.                                                                                                                                                               |
| Strategy formulation/delivery and forward planning | • Giving governors the opportunity to feed in their views and those of members and the public.  
• Responding to questions on proposed significant transactions etc  
• Involving governors in identifying and prioritising quality priorities  
• Receiving information on increasing non-NHS income as a percentage of total Trust income by 5% a year or more (for example from 3% of total Trust income to 8.0%)  
• Challenge and constructive support on strategic direction and clinical strategy  
• Reporting on response to important sector /strategic issues | Strategic plan                                                                                                                                                                                                                     |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Clinical strategy                                                                                                                                                                                                                    |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Estates strategy                                                                                                                                                                                                                        |
|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Significant service changes and investments (OBC, FBC)                                                                                                                                                                                  |
Council of Governors  
14 April 2015  
Agenda Item 9

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Actions by Governors</th>
<th>Relevant Documents</th>
</tr>
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</table>
| Assurance processes and outcomes | • Receiving an annual risk assessment and management report (processes and structures to deal with key risks).  
• Receiving an annual report and updates from the Audit Committee  
• Receiving report on the Board’s assurance framework  
• Receiving and review quarterly assurance Reports  
• Reviewing other assurance reports eg Health & Safety, Annual Staff Survey | Assurance reports eg Health & Safety, annual staff survey |
| Culture and values (incl. staff wellbeing and satisfaction) | • Receiving a progress report on vision, values and standards of conduct  
• Challenge and support on staff engagement, response to staff survey results, staff training, staff performance reviews, staff health and wellbeing, customer service training, and the many factors that contribute to a strong and positive culture of care | Annual staff survey  
Health & Safety strategy and updates  
Workforce and OD report  
Customer care updates  
Francis Enquiry actions |

**Routinely governors should:**

- receive the agenda of the meetings of the board of directors before the meeting takes place.  
- contribute to the appraisals of the chair and other NEDs.  
- hold six monthly meetings, in camera, with NEDs.  
- observe the contributions of the NEDs at public board and other meetings with governors.  
- from time to time attend public board meetings.  
- take advantage of opportunities to review services and environments such as PLACE inspections/quality reviews/local activities and evaluation of user/carer experience.

**In addition governors:**

- are responsible for appointing the chair and other NEDs and may remove them in the event of unsatisfactory performance.  
- have the power to appoint or remove the auditor.  
- where applicable, put questions to the Panel for Advising Governors where the circumstances meet the requirements in the 2006 Act, as amended.  
- as a last resort, may engage in a dialogue with Monitor through the lead governor.
• may invite NEDs to appropriate meetings of governors.
• may, if considered necessary, as a last resort, in the fulfilment of their duties, obtain information about the foundation trust's performance or the directors' performance by requiring one or more directors to attend a council meeting.

Implementation Plan

1. The Forward Look document (Lead Governor’s e-mail dated 2.5.14 refers) will, as it evolves, provide the basis for implementing the core elements of the process i.e. the reports from NEDs and the Board.

   The aim is that the Forward Look will contain a schedule of the assurance reports Governors from the NEDs/Board, to enable Governors to exercise their statutory responsibility of holding NEDs to account.

2. The amendment where appropriate and relevant of HR documents to include the responsibilities of NEDs to Council e.g. the following line could be inserted in future Non-Executive Director Job Descriptions: ‘All Non-Executive Directors are line managed by the Chair of the Trust. The Trust’s Constitution sets out the relationship between Non-Executives and the Council of Governors’.

3. The addition of two new ‘drop-in’ sessions per year. These would be for members of the Council of Governors to meet with those Non-Executive Directors that are available to have an informal and wide-ranging discussion on current issues facing the Trust.

   It is considered that these three main components will provide Council with sufficient opportunities to fulfil its duty to hold NEDs individually and collectively to account for the performance of the Board of Directors.

Component 1 is the responsibility of the Trust’s Director of Organisational Development & Leadership on behalf of Council and is overseen by Council’s Nomination & Remuneration Committee, with completion by the next meeting of that Committee on 6 November 2014 or by the next NED recruitment campaign if begun earlier; implementation of components 2 and 3 is the responsibility of the Trust’s Company Secretary, by 30 September 2014.
Proposal to establish a Deputy Lead Governor Role

Introduction:

1.1 To establish an elected position of Deputy to the Lead Governor, so that in the event of the LG’s unavailability or incapacity – through illness, accident, holiday etc – a Governor is already designated to stand in for the LG and to fulfil the functions of that role, without delay to Council business.

1.2 To ensure a robust procedure for a replacement LG if the LG becomes unable to carry out their role if a ‘what if’ situation arises. In effect providing a contingency plan for sound governance.

1.3 The Lead Governor for WSHT has a number of roles and duties in addition to the basic requirements set out by Monitor. As a result she commits much time to her role, which is much appreciated by all. Margaret is well supported by a number of governors who assist her when she is unavailable and this proposal is not intended to detract from the current modus operandi and certainly one with no hierarchical intention.

1.4 By creating an opportunity for Council to choose a Deputy LG, the possibility to stand as LG would be opened up for a Governor who may fear that business commitments, for example, would be incompatible with the LG role as it has currently developed.

The role of Deputy Lead Governor

2.1 The Deputy Lead Governor shall perform the duties of the Lead Governor in their absence.

2.2 The term of office of the Deputy Lead Governor is one year or until their term of office on the Council comes to an end, whichever is the sooner. The Deputy Lead Governor may stand for re-election for as long as they are a member of the Council.

Election Process

3.1 The Constitution to be that Deputy Lead Governors should be elected annually and for the election to take place at the same time as that for the Lead Governor.

3.2 The Deputy Lead Governor to serve a full year in this role.

3.3 The election process to be the same as that for the Lead Governor.

Proposal

For the Council of Governors to decide whether to introduce the role of Deputy Lead Governor to our Constitution.
Please note that I have drawn information for the above from a number of other NHS Foundation Trusts not exclusively, but including: South East Coast Ambulance Service NHS Foundation Trust; Great Western Hospitals NHS Foundation Trust; West Midlands Ambulance Service NHS Foundation Trust; Basildon and Thurrock University Hospitals; Salisbury NHS Foundation Trust.